



Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address:	MFDR Tracking #: M4-11-3531-01
	DWC Claim #:
	Injured Employee:
	Date of Injury:
Respondent Name and Carrier's Austin Representative Box #: ST PAUL FIRE & MARINE INSURANCE Box #: 05	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Requestor's Rationale for Increased Reimbursement: "To control and minimize pain/per Dr."

Amount in Dispute: \$722.54

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This request for medical fee dispute resolution should be dismissed in accordance with Rule 133.307(e)(3)(I) as the claimant failed to submit the disputed services to the carrier prior to filing for medical fee dispute resolution in accordance with Rule 133.270, and should further be dismissed in accordance with Rule 133.307(e)(3)(G) as the basis for the carrier's denial of these service is found on a lack of medical necessity."

Response Submitted by: Travelers, 1401 S. Mopac Expressway, Ste. A-320, Austin, TX 78746

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
11/09/2010 – 06/10-2011	Out of Pocket expenses/Prescription Medication	N/A	722.54	\$0.00
			Total Due:	\$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
- 28 Tex. Admin. Code §133.270 sets out the procedures for injured employees to submit receipts for out-of-pocket expenses the injured worker incurred for medical treatment and/or medications to the insurance carrier for reimbursement.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - Neither party submitted explanation of benefits for the above dates of service.

Issues

- Did the requestor submit the receipts for out-of-pocket expenses for prescription medications to the Carrier in accordance with 28 Tex. Admin. Code §133.270?
- Are there medical necessity issues in regards to the prescription medications?

Findings

1. The Respondent states in their position summary that the Requestor did not submit the disputed services to the Carrier prior to filing for medical fee dispute resolution. The documentation submitted by the Requestor does not contain a copy of the carrier's or health care provider's denial of reimbursement or refund relevant to the dispute, or convincing evidence of the employee's attempt to obtain reimbursement or refund from the carrier or health care provider pursuant to 28 Tex. Admin. Code §133.307(c)(3)(D).
2. The Respondent states in their position summary that the basis for the carrier's denial of these services was a lack of medical necessity. In accordance with 28 Tex. Admin. Code §133.305(a)(10) a dispute that involves a review of the medical necessity of health care already provided is reviewed by an IRO pursuant to the Insurance Code, Labor Code and related rules, including §133.308 of this subchapter.

Conclusion

For the reasons stated above, the division finds that the requestor has failed to establish that reimbursement is due. As a result, the amount ordered is \$0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Medical Fee Dispute Resolution Officer

Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.